

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 01/28/2013	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410			
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W0000	<p>This visit was for the investigation of Complaint #IN00122535.</p> <p>COMPLAINT #IN00122535: Substantiated, Federal/State deficiencies related to the allegation are cited at W186, W192, W210, W318, W331, and W436.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: January 22, 23, 24, 25, and 28, 2013.</p> <p>Facility number: 001067 Provider number: 15G553 AIM number: 100245460</p> <p>Surveyors: Tim Shebel, Medical Surveyor III-Team Leader (1/22/13 through 1/28/13) Amber Bloss, Medical Surveyor III (1/22/13 through 1/25/13) Janet Adams, Public Health Nurse Surveyor III (1/23/13)</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/4/13 by Ruth Shackelford, Medical Surveyor III.</p>		W0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013

FORM APPROVED

OMB NO. 0938-0391

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview, the facility failed to provide sufficient staff numbers to transfer without injury for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/22/13 at 11:34 A.M.. The review indicated the following incidents involving client A:</p> <p>1. "Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory</p>		W0186	<p>The Service Coordinator and Area Manager will ensure that the house is staffed to the requirement. To ensure future compliance, an automated system has been put in place to notify the Area Manager if staff do not clock in within 15 minutes of the beginning of their shift.</p>		02/19/2013	

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	<p>tests) were all normal. A CAT scan (computerized scan) of the head, chest and abdomen came back normal also. Consult with surgeon for spinal stenosis came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities."</p> <p>"Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hooyer lift (lifting device) should be implemented as soon as possible." Further review of the 12/31/12 incident report indicated action taken by LPN (Licensed Practical Nurse) #1: "[Client A] was refusing staff assistance on the evening of the 28th (12/28/12). When staff attempted to transfer her she fought and slid down to the floor. No injury</p>						

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	<p>occurred from that but staff called for assistance to get her (client A) off the floor. She (client A) sustained the bruise and scratch while getting her up and into bed."</p> <p>"Date: 01/08/2013, Name: [client A], Narrative: Received phone call from group home staff approximately 9:00pm stating that [client A] had slid herself down, with staff assistance, to the floor. {This behavior is in her behavior plan}. Staff needed assistance to get her up since [client A] is unable to assist. Instructed staff to call area manager to send additional staff over to help. Received a second call for staff stating that [client A] had stopped breathing and 911 had been called. Plan to Resolve: Second staff started CPR (Cardio-Pulmonary Resuscitation) and continued until medics arrived and took over. [Client A] was taken to [local hospital] and intubated (breathing tube placed). She remains on life support at this time."</p> <p>Client A's record was reviewed on 1/22/13 at 12:01 P.M.. A review of the client's 1/12 behavior management plan failed to indicate client A had an addressed behavior of sliding down to floor from a seated position. A 11/27/12 facility nursing assessment indicated the client was, "Very tired and lethargic.</p>						

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	<p>Won't feed herself or help transfer."</p> <p>Review of a hospital discharge summary, dated 12/12/12, included a Rehab (rehabilitation) Evaluation which indicated client A had a Rehab Diagnoses of: "Frequent fall (sic) with chest pain, and, Gait disturbance with General weakness." A review of client A's "Fall Risk Plan", dated 11/12, indicated "[Client A] uses a wheelchair and a gait belt to ambulate."</p> <p>Client A's records were further reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records indicated the client was 83 years of age at the time of her death and had a history of recent hospitalizations for chest pain and congestive heart failure. Review of the client's hospital records from hospitalizations in November, 2012, December, 2012 and January, 2103 indicated client A had a history of chronic and acute heart disease. Review of the client's 1/8/13 to 1/10/13 hospital and physician records failed to indicate the group home transfers of client A had contributed to the client's 1/8/13 cardiac arrest.</p> <p>Direct care staff #1 was interviewed on 1/22/13 at 5:45 P.M.. Direct care staff #1 stated client A "would not help with transfers and would often slide to the</p>						

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	<p>floor when being transferred due to her weakness. On the Tuesday that she went back to the hospital (1/8/13), [Direct care staff #2] and I transferred her to the toilet from her wheel chair. When she said she was done, she tried to move her back to her wheel chair but she slid down to the floor and we couldn't get her back up. [Direct care staff #2] went and got some sheets and we rolled [client A] into the sheets and carried her to her bedroom. We couldn't lift her so [direct care staff #2] called the area manager to get another person over to the group home so we could put her in bed. [Direct care staff #2] doesn't usually work this group home and she is a small person so her and I could not lift her (client A) by ourselves."</p> <p>Direct care staff #2 was interviewed on 1/23/13 at 9:55 A.M.. Direct care staff #2 stated, "We (direct care staff #1 and #2) were unable to transfer [client A] from the toilet back to her wheelchair on that Tuesday night (1/8/13). We lowered her to the floor and then I went and got some sheets and we rolled her (client A) into the sheets and carried her to her room. I then went and called the area manager so she would send someone over to help us get her (client A) back into bed.</p> <p>Service Coordinator #1 was interviewed on 1/23/13 at 10:37 A.M.. Service</p>						

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	<p>Coordinator #1 stated, "Sliding out of her (client A's) wheelchair started in November (2012) and it occurred on three occasions, December 1st (2012), December 31st (2012), and January 8th (2013). When she slides to the floor it takes a good three people to pick her up."</p> <p>Staffing records for December 2012 and January 2013 were reviewed on 1/23/13 at 2:15 P.M.. A review of staffing numbers for the group home for December 1st, 2012 indicated two staff were on duty when client A slid from her wheelchair during a transfer. On December 31st, 2012, two staff were on duty when client A slid from her wheel chair during a transfer. On January 8th, 2013, 2 staff were on duty when client A slid to the floor during a transfer.</p> <p>This federal relates to complaint #IN00122535.</p> <p>9-3-3(a)</p>						

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W0192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed to train direct care staff on appropriate transfer methods for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/22/13 at 11:34 A.M.. The review indicated the following incidents involving client A:</p> <p>"Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory tests) were all normal. A CAT scan (computerized scan) of the head, chest and abdomen came back normal also. Consult with surgeon for spinal stenosis</p>		W0192	<p>All staff working at this facility will be trained on the following: Transferring and transporting client safely, behavior plans were applicable, medical signs and symptoms, and reporting changes in client condition.</p>		02/19/2013	

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	<p>came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities."</p> <p>"Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hooyer lift (lifting device) should be implemented as soon as possible." Further review of the 12/31/12 incident report indicated action taken by LPN (Licensed Practical Nurse) #1: "[Client A] was refusing staff assistance on the evening of the 28th (12/28/12). When staff attempted to transfer her she fought and slid down to the floor. No injury occurred from that but staff called for assistance to get her (client A) off the floor. She (client A) sustained the bruise and scratch while getting her up and into</p>						

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	<p>bed."</p> <p>"Date: 01/08/2013, Name: [client A], Narrative: Received phone call from group home staff approximately 9:00pm stating that [client A] had slid herself down, with staff assistance, to the floor. {This behavior is in her behavior plan}. Staff needed assistance to get her up since [client A] is unable to assist. Instructed staff to call area manager to send additional staff over to help. Received a second call for staff stating that [client A] had stopped breathing and 911 had been called. Plan to Resolve: Second staff started CPR (Cardio-Pulmonary Resuscitation) and continued until medics arrived and took over. [Client A] was taken to [local hospital] and intubated (breathing tube placed). She remains on life support at this time."</p> <p>Client A's records were reviewed on 1/22/13 at 12:01 P.M.. A review of the client's 1/12 behavior management plan failed to indicate client A had an addressed behavior of sliding down to floor from a seated position. A 11/27/12 facility nursing assessment indicated the client was, "Very tired and lethargic. Won't feed herself or help transfer." Review of a hospital discharge summary, dated 12/12/12, included a Rehab (rehabilitation) Evaluation which</p>						

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	<p>indicated client A had Rehab Diagnoses which included but were not limited to: "Frequent fall with chest pain, and, Gait disturbance with General weakness."</p> <p>Client A's records were further reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records indicated the client was 83 years of age at the time of her death and had a history of recent hospitalizations for chest pain and congestive heart failure. Review of the client's hospital records from hospitalizations in November, 2012, December, 2012 and January, 2103 indicated client A had a history of chronic and acute heart disease. Review of the client's 1/8/13 to 1/10/13 hospital and physician records failed to indicate the group home transfers of client A had contributed to the client's 1/8/13 cardiac arrest.</p> <p>Direct care staff #1 was interviewed on 1/22/13 at 5:45 P.M.. Direct care staff #1 stated client A "would not help with transfers and would often slide to the floor when being transferred due to her weakness." When asked if she had been trained on transfers, direct care staff #2 stated, "No."</p> <p>Direct care staff #2 was interviewed on 1/23/13 at 9:55 A.M.. When asked if she</p>						

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	<p>had been trained on transfers, direct care staff #2 stated, "Yes, when I first started work here."</p> <p>Direct care staff #1's training records were reviewed on 1/24/13 at 12:34 P.M.. A review of direct care staff #1's training records indicated she had not received training in techniques in transferring individuals.</p> <p>Direct care staff #2's training records were reviewed on 1/24/13 at 12:37 P.M.. A review of direct care staff #2's training records indicated she had last been trained on transferring individuals on 7/31/2006.</p> <p>This federal relates to complaint #IN00122535.</p> <p>9-3-3(a)</p>						

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed to assess the transfer needs of 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/22/13 at 11:34 A.M.. The review indicated the following incidents involving client A:</p> <p>"Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory tests) were all normal. A CAT scan (computerized scan) of the head, chest and abdomen came back normal also. Consult with surgeon for spinal stenosis</p>		W0210	<p>On December 17, 2012 a team meeting was held to discuss CL A current condition and potential changes to her programming and medical treatment. CL A repeated falls were discussed and since the team saw this as a symptom of her current medical condition the team chose to follow a medical rout of treatment rather than label it as a behavior. Whoever stated that sliding out of her chair was in her behavior plan was in error. Rather the team made appointments for CL A to be evaluated by a physical therapist on December 4, 2012 and January 9, 2013 to see if strength training exercises or adaptive equipment would be appropriate for her case. Despite one instance of her sliding out of her chair following this team meeting the direction of care maintained.</p> <p>2/25/13 To ensure future compliance any changes in client condition will be evaluated by the team or the appropriate professional based on the presenting change within 2 days of knowledge.</p>		02/19/2013	

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	<p>came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities."</p> <p>Client A's record was reviewed on 1/22/13 at 12:03 P.M.. The review failed to indicate the PT/OT evaluation.</p> <p>"Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hoier lift (lifting device) should be implemented as soon as possible." Further review of the 12/31/12 incident indicated Action taken by LPN (Licensed Practical Nurse) #1: "[Client A] was refusing staff assistance on the evening of the 28th (12/28/12). When staff attempted to transfer her she fought and slid down to the floor. No injury occurred</p>						

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	<p>from that but staff called for assistance to get her (client A) off the floor. She (client A) sustained the bruise and scratch while getting her up and into bed."</p> <p>"Date: 01/08/2013, Name: [client A], Narrative: Received phone call from group home staff approximately 9:00pm stating that [client A] had slid herself down, with staff assistance, to the floor. {This behavior is in her behavior plan}. Staff needed assistance to get her up since [client A] is unable to assist. Instructed staff to call area manager to send additional staff over to help. Received a second call for staff stating that [client A] had stopped breathing and 911 had been called. Plan to Resolve: Second staff started CPR (Cardio-Pulmonary Resuscitation) and continued until medics arrived and took over. [Client A] was taken to [local hospital] and intubated (breathing tube placed). She remains on life support at this time."</p> <p>Client A's record was reviewed on 1/22/13 at 12:01 P.M.. A review of the client's 1/12 behavior management plan failed to indicate client A had an addressed behavior of sliding down to floor from a seated position. A 11/27/12 facility nursing assessment indicated the client was, "Very tired and lethargic. Won't feed herself or help transfer.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	<p>Review of a hospital discharge summary, dated 12/12/12, included a Rehab (rehabilitation) Evaluation which indicated client A had Rehab Diagnoses which included but were not limited to: "Frequent fall with chest pain, and, Gait disturbance with General weakness." A review of a 12/13/12 facility nursing assessment failed to assess client A's diagnoses of frequent falls, gait disturbance with general weakness and failed to address the client's transfer needs.</p> <p>Client A's records were further reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records indicated the client was 83 years of age at the time of her death and had a history of recent hospitalizations for chest pain and congestive heart failure. Review of the client's hospital records from hospitalizations in November, 2012, December, 2012 and January, 2103 indicated client A had a history of chronic and acute heart disease. Review of the client's 1/8/13 to 1/10/13 hospital and physician records did not indicate the group home transfers of client A had contributed to the client's 1/8/13 cardiac arrest.</p> <p>Service Coordinator #1 was interviewed on 1/23/13 at 10:37 A.M.. Service</p>						

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	<p>Coordinator #1 stated, "Sliding out of her (client A's) wheelchair started in November (2012) and it occurred on three occasions, December 1st (2012), December 31st (2012), and January 8th (2013)."</p> <p>LPN #1 was interviewed on 1/23/13 at 12:01 P.M.. When asked if client A's transfer needs had been assessed, LPN #1 stated, "No."</p> <p>This federal relates to complaint #IN00122535.</p> <p>9-3-4(a)</p>						

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation of Health Care Services is not met as the facility failed to assure 1 of 3 sampled clients (Client A) received adequate health care assessments, monitoring and services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W186 as the facility failed to provide sufficient staff numbers to transfer without injury for 1 of 3 sampled clients (client A). 2. Please refer to W192 as the facility failed to train direct care staff on appropriate transfer methods for 1 of 3 sampled clients (client A). 3. Please refer to W210 as the facility failed to assess the transfer needs of 1 of 3 sampled clients (client A). 4. Please refer to W331 as the facility failed to provide adequate nursing services: 1. To assess, implement, provide sufficient staff, and provide staff training in regards to a method of transferring 1 of 3 sampled clients (client A) without causing injury to the client, 2. To provide adequate health monitoring 			W0318	Please see W186; W192; W210, and see W331.		02/19/2013

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	<p>(pulse and blood pressure) in accordance with client needs for 1 of 3 sampled clients (client A), 3. To provide adequate documentation for the effectiveness of PRN (as needed) medications after administration for 1 of 3 sampled clients (client A), and 4. To administer medications per physician's orders for 1 of 3 sampled clients (client A).</p> <p>5. Please refer to W436 as the facility failed to assure 1 of 3 sampled clients (client A) utilized a gait belt as indicated.</p> <p>This federal tag relates to complaint #IN00122535.</p> <p>9-3-6(a)</p>						

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed to provide adequate nursing services: 1. To assess, implement, provide sufficient staff, and provide staff training in regards to a method of transferring 1 of 3 sampled clients (client A) without causing injury to the client, 2. To provide adequate health monitoring (pulse and blood pressure) in accordance with client needs for 1 of 3 sampled clients (client A), 3. To provide adequate documentation for the effectiveness of PRN (as needed) medications after administration for 1 of 3 sampled clients (client A), and 4. To administer medications per physician's orders for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/22/13 at 11:34 A.M.. The review indicated the following incidents involving client A:</p> <p>1. "Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was</p>			W0331	<p>Nursing services will be involved in developing systems for monitoring and training staff on the following: transferring and transporting client safely, medical signs and symptoms, reporting changes in client condition, monitoring and document pulse, monitoring and document blood pressure, transferring medication orders, and documenting the use of PRN medications.</p> <p>To ensure future compliance, all new staff will be trained on these topics and all staff will be retrained annually. The Area Manager will ensure the staff training records are up to date.</p>		02/19/2013

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	<p>complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory tests) were all normal. A CAT scan (computerized scan) of the head, chest and abdomen came back normal also. Consult with surgeon for spinal stenosis came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities."</p> <p>"Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence (sic) of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hoier lift (lifting device) should be implemented as soon as possible."</p>						

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	<p>Further review of the 12/31/12 incident indicated action taken by LPN (Licensed Practical Nurse) #1: "[Client A] was refusing staff assistance on the evening of the 28th (12/28/12). When staff attempted to transfer her she fought and slid down to the floor. No injury occurred from that but staff called for assistance to get her (client A) off the floor. She (client A) sustained the bruise and scratch while getting her up and into bed."</p> <p>"Date: 01/08/2013, Name: [client A], Narrative: Received phone call from group home staff approximately 9:00pm stating that [client A] had slid herself down, with staff assistance, to the floor. {This behavior is in her behavior plan}. Staff needed assistance to get her up since [client A] is unable to assist. Instructed staff to call area manager to send additional staff over to help. Received a second call for staff stating that [client A] had stopped breathing and 911 had been called. Plan to Resolve: Second staff started CPR (Cardio-Pulmonary Resuscitation) and continued until medics arrived and took over. [Client A] was taken to [local hospital] and intubated (breathing tube placed). She remains on life support at this time."</p> <p>Client A's record was reviewed on 1/22/13 at 12:01 P.M.. A review of the</p>						

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	<p>client's 1/12 behavior management plan failed to indicate client A had an addressed behavior of sliding down to floor from a seated position. A 11/27/12 facility nursing assessment indicated the client was, "Very tired and lethargic. Won't feed herself or help transfer." Review of a hospital discharge summary, dated 12/12/12, included a Rehab (rehabilitation) Evaluation which indicated client A had Rehab Diagnoses which included but were not limited to: "Frequent fall with chest pain, and, Gait disturbance with General weakness." A review of a 12/13/12 facility nursing assessment failed to assess client A's diagnoses of frequent falls, gait disturbance with general weakness and failed to address the client's transfer needs. A review of client A's "Fall Risk Plan", dated 11/12, indicated "[Client A] uses a wheelchair and a gait belt to ambulate."</p> <p>Client A's records were further reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records indicated the client was 83 years of age at the time of her death and had a history of recent hospitalizations for chest pain and congestive heart failure. Review of the client's hospital records from hospitalizations in November, 2012, December, 2012 and January, 2103</p>						

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	<p>indicated client A had a history of chronic and acute heart disease. Review of the client's 1/8/13 to 1/10/13 hospital and physician records did not indicate the group home transfers of client A had contributed to the client's 1/8/13 cardiac arrest.</p> <p>Direct care staff #1 was interviewed on 1/22/13 at 5:45 P.M.. Direct care staff #1 stated client A "would not help with transfers and would often slide to the floor when being transferred due to her weakness." When asked if client A had any lift or gait belt to assist in transferring her, direct care staff #1 stated, "There was a hooyer lift that came that day (1/8/13) but there were no pads that came with it so we couldn't use it and she (client A) didn't have a gait belt that I know of." Direct care staff #1 further stated, "We (direct care staff working at the group home) would try to transfer her but she was just dead weight. If she got a bruise or a scratch it was from picking her up off of the floor and putting her in her wheelchair or into bed. On the Tuesday that she went back to the hospital (1/8/13), [Direct care staff #2] and I transferred her to the toilet from her wheel chair. When she said she was done, she tried to move her back to her wheel chair but she slid down to the floor and we couldn't get her back up. [Direct care staff #2] went and got some</p>						

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	<p>sheets and we rolled [client A] into the sheets and carried her to her bedroom. We couldn't lift her so [direct care staff #2] called the area manager to get another person over to the group home so we could put her in bed. [Direct care staff #2] doesn't usually work this group home and she is a small person so her and I could not lift her (client A) by ourselves. As she was calling, I noticed [client A] looking like she was sleeping so I checked her and she was not breathing. I yelled for [direct care staff #2] to call 911 and I started CPR and continued until the ambulance came and they took over (CPR)." When asked if she had been trained on transfers, direct care staff #2 stated, "No."</p> <p>Direct care staff #2 was interviewed on 1/23/13 at 9:55 A.M.. Direct care staff #2 stated, "We (direct care staff #1 and #2) were unable to transfer [client A] from the toilet back to her wheelchair on that Tuesday night (1/8/13). We lowered her to the floor and then I went and got some sheets and we rolled her (client A) into the sheets and carried her to her room. I then went and called the area manager so she would send someone over to help us get her (client A) back into bed. [Direct care staff #2] said [client A] wasn't breathing and she immediately started CPR. The ambulance came and they took</p>						

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	<p>over (CPR)." When asked if client A had a gait belt or any other device to assist with transfers, direct care staff #3 stated, "No, no gait belt but there was a hooyer lift that was delivered to the group home on that Tuesday (1/8/13). We couldn't use it because the pads that were supposed to come with it didn't come." When asked if she had been trained on transfers, direct care staff #2 stated, "Yes, when I first started work here."</p> <p>Client A's records were reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records indicated the client was 83 years of age at the time of her death and had a history of recent hospitalizations for chest pain and congestive heart failure. Review of the client's hospital records from hospitalizations in November, 2012, December, 2012 and January, 2013 indicated client A had a history of chronic and acute heart disease. Review of the client's 1/8/13 to 1/10/13 hospital and physician records did not indicate the group home transfers of client A had contributed to the client's 1/8/13 cardiac arrest.</p> <p>Direct care staff #1's training records were reviewed on 1/24/13 at 12:34 P.M.. A review of direct care staff #1's training records indicated she had not received</p>						

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	<p>training in techniques in transferring individuals.</p> <p>Direct care staff #2's training records were reviewed on 1/24/13 at 12:37 P.M.. A review of direct care staff #2's training records indicated she had last been trained on transferring individuals on 7/31/2006.</p> <p>Service Coordinator #1 was interviewed on 1/23/13 at 10:37 A.M.. Service Coordinator #1 stated, "Sliding out of her (client A's) wheelchair started in November (2012) and it occurred on three occasions, December 1st (2012), December 31st (2012), and January 8th (2013). When she slides to the floor it takes a good three people to pick her up. A hoier lift was initially ordered around the middle of December (2012)." Service Coordinator #1 further stated, "We didn't use it because we were waiting for a physician's order to start using it. We were going to finally decide in January at her (client A's) annual meeting."</p> <p>Staffing records for December 2012 and January 2013 were reviewed on 1/23/13 at 2:15 P.M.. A review of staffing numbers for the group home for December 1st, 2012 indicated two staff were on duty when client A slid from her wheelchair during a transfer. On December 31st, 2012, two staff were on duty when client</p>						

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	<p>A slid from her wheel chair during a transfer. On January 8th, 2013, 2 staff were on duty when client A slid to the floor during a transfer.</p> <p>LPN #1 was interviewed on 1/23/13 at 12:01 P.M.. LPN #1 stated, "[Client A] required two person transfers. No devices (hoyer lift) were being used. We were talking about getting a hoyer lift but hadn't gotten one. A two person transfer was rough because [client A] was no help. She had not been able to assist with transfers for at least the last couple of months." When asked if client A's transfer needs had been assessed, LPN #1 stated, "No."</p> <p>2. On 1/23/13 at 1:30 PM a record review indicated client A's diagnoses included, but were not limited to, depression, right eye prosthesis, arthritis, psychosis, mental retardation and cardiovascular disease. Client A's Medication Administration Record (MAR) dated for December 2012 (12/1/12-12/31/12) and January 2013 (1/1/13-1/31/13) were reviewed and indicated staff were to take Client A's blood pressure and pulse twice daily.</p> <p>The December 2012 MAR, reviewed on 1/23/13 at 1:35 PM, indicated staff documented Client A's blood pressure twice in the month of December 2012.</p>						

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	<p>The MAR indicated staff did not document client A's pulse in the month of December 2012. The MAR indicated client A was present in the facility home 18 days in December and in the hospital 11 days.</p> <p>The January 2013 MAR, reviewed on 1/23/13 at 1:38 PM, indicated staff documented Client A's pulse one time on 1/8/13. The MAR indicated Client A was in the facility home for 8 days in January 2013.</p> <p>On 1/24/13 at 10:35 AM during an interview, RN (registered nurse) #1 indicated staff should have been documenting client A's blood pressure and pulse as indicated on the MAR.</p> <p>On 1/23/13 at 2:35 PM during an interview, Service Coordinator #1 indicated staff should have been documenting client A's blood pressure and pulse as indicated in her MAR. Service Coordinator #1 indicated staff should have also been documenting client A's blood pressure and pulse in the daily logs.</p> <p>On 1/23/13 at 2:45 PM, the daily logs were reviewed for client A for dates 12/1/12 to 1/2/13. Staff documented client A's blood pressure on the daily log</p>						

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	<p>for 1/2/13 only. No further documentation for the monitoring of client A's blood pressure and pulse was provided.</p> <p>3. On 1/23/13 at 1:30 PM a record review indicated client A's diagnoses included, but was not limited to, depression, right eye prosthesis, arthritis, psychosis, mental retardation and cardiovascular disease. Client A's Medication Administration Record (MAR) dated for December 2012 (12/1/12-12/31/12) and January 2013 (1/1/13-1/31/13) were reviewed. The January 2013 MAR indicated client A was given a PRN (as needed) of Guiatuss (cough medicine) 30 ML in the morning of 1/2/13 and 3 times daily (morning, dinner, bedtime) on 1/3/13, 1/4/13, 1/5/13, 1/6/13, 1/7/13, and 1/8/13.</p> <p>Review on 1/23/13 at 1:38 PM of the MAR for January 2013 also indicated client A was administered another PRN of Robafen-DM syrup (cough medicine) 4 times daily (morning, lunch, dinner, bedtime) on 1/1/13, 1/2/13, 1/3/13, 1/4/13, 1/5/13, 1/6/13, 1/7/13, and at bedtime on 1/8/13.</p> <p>Client A's records were further reviewed on 1/23/13 at 10:07 A.M.. Review of client A's medical records and lab results</p>						

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	<p>from 1/8/13 did not indicate the client had a toxic level of cough medications in her system at the time of her 1/8/13 hospitalization.</p> <p>On 1/24/13 at 10:35 AM during an interview, RN #1 indicated there was no documentation on the MAR indicating the reason for the PRN nor the effectiveness of the PRNs given to client A between 1/1/13 to 1/8/13. RN #1 indicated staff were trained to document a reason for a PRN and to monitor the effectiveness of PRNs on the client's MAR. RN #1 indicated staff were certified in Med Core A and B (basic medication administration).</p> <p>On 1/24/13 at 11:35 AM, the facility "Medication Administration Procedure" policies (undated, received from RN #1 as current) were reviewed. The facility procedure indicated "administration of PRN medications will be charted on the indicated dosage, route, time of administration, and effectiveness."</p> <p>4. On 1/23/13 at 1:30 PM a record review indicated client A's diagnoses included, but not limited to, depression, right eye prosthesis, arthritis, psychosis, mental retardation and cardiovascular disease. A comprehensive metabolic panel (blood</p>						

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	<p>metabolic panel) collected on 1/03/2013 indicated client A had an elevated Potassium level of 6.4 mmol/L which is above the normal limits of 3.5-5.3 mmol/L.</p> <p>A review on 1/23/13 at 1:45 PM of client A's physician orders written on 1/4/13 indicated the client had a prescription for two doses of Kayexalate 30gms (known to assist in decreasing Potassium levels in the body) and an order to discontinue Klor-Con (Potassium Chloride) and Losartan (Losartan Potassium).</p> <p>A review on 1/23/13 at 1:56 PM of client A's Medication Administration Record (MAR) dated for 1/01/13 to 1/31/13 indicated client A had a prescription of Potassium CL (Potassium Chloride) 30 ML daily and Losartan Potassium 100mg tablet daily.</p> <p>A review of client A's MAR on 1/23/13 at 2:02 PM indicated Potassium CL continued to be administered after the order to discontinue (1/4/13). The Potassium CL was signed by staff as administered on 1/5/13, 1/6/13, and 1/7/13.</p> <p>A review of client A's MAR on 1/23/13 at 2:03PM indicated the Losartan Potassium continued to be given after the order to</p>						

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	<p>discontinue (1/4/13). The Losartan Potassium was signed by staff as administered on 1/5/13, 1/6/13, and 1/7/13.</p> <p>A review on 1/14/13 at 11:00 AM of client A's 1/8/13 lab results indicated the client's potassium level was within normal limits.</p> <p>On 1/24/13 at 12:05 PM, an interview with Pharmacist #1 indicated the pharmacy received a fax with the order to discontinue the Potassium CL and the Losartan Potassium on 1/4/13.</p> <p>On 1/24/13 at 12:35 PM, an interview with LPN (Licensed Practical Nurse) #1 indicated she was aware the Potassium CL and Losartan Potassium for client A had been discontinued on 1/4/13. LPN #1 indicated she had informed the staff with a fax memo of the discontinuation but acknowledged upon review of client A's MAR, they continued to give both medications for another 3 days.</p> <p>This federal tag relates to complaint #IN00122535.</p> <p>9-3-6(a)</p>						

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PRINTED: 03/06/2013

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to administer: 1. Potassium medications and, 2. Cough medications per physician's orders for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>1. On 1/23/13 at 1:30 PM a record review indicated client A's diagnoses included, but not limited to, depression, right eye prosthesis, arthritis, psychosis, mental retardation and cardiovascular disease. A comprehensive metabolic panel (blood metabolic panel) collected on 1/03/2013 indicated client A had an elevated Potassium level of 6.4 mmol/L which is above the normal limits of 3.5-5.3 mmol/L.</p> <p>A review on 1/23/13 at 1:45 PM of client A's physician orders written on 1/4/13 indicated the client had a prescription for two doses of Kayexalate 30gms (known to assist in decreasing Potassium levels in the body) and an order to discontinue Klor-Con (Potassium Chloride) and Losartan (Losartan Potassium).</p> <p>A review on 1/23/13 at 1:56 PM of client</p>			W0368	<p>The policy on medication administration, documentation of PRN medications, transferring orders to the MAR, and monitoring that the orders were transcribed correctly was updated on 1/31/13. To ensure future compliance this policy will be reviewed annually and revised as needed.</p>		02/19/2013

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	<p>A's Medication Administration Record (MAR) dated for 1/01/13 to 1/31/13 indicated client A had a prescription of Potassium CL (Potassium Chloride) 30 ML daily and Losartan Potassium 100mg tablet daily.</p> <p>A review of client A's MAR on 1/23/13 at 2:02 PM indicated Potassium CL continued to be administered after the order to discontinue (1/4/13). The Potassium CL was signed by staff as administered on 1/5/13, 1/6/13, and 1/7/13.</p> <p>A review of client A's MAR on 1/23/13 at 2:03PM indicated the Losartan Potassium continued to be given after the order to discontinue (1/4/13). The Losartan Potassium was signed by staff as administered on 1/5/13, 1/6/13, and 1/7/13.</p> <p>A review on 1/14/13 at 11:00 AM of client A's 1/8/13 lab results indicated the client's potassium level was within normal limits.</p> <p>On 1/24/13 at 12:05 PM, an interview with Pharmacist #1 indicated the pharmacy received a fax with the order to discontinue the Potassium CL and the Losartan Potassium on 1/4/13.</p>						

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	<p>On 1/24/13 at 12:35 PM, an interview with LPN (Licensed Practical Nurse) #1 indicated she was aware the Potassium CL and Losartan Potassium for client A had been discontinued on 1/4/13. LPN #1 indicated she had informed the staff with a fax memo of the discontinuation but acknowledged upon review of client A's MAR, they continued to give both medications for another 3 days.</p> <p>2. On 1/23/13 at 1:30 PM a record review of the MAR for January 2013 included a PRN order for Guiatuss 100MG/5ML syrup to give 30 ML orally 3 times a day as needed" and a PRN order for Robafen-DM cough syrup to "give 10 ML (2 teaspoonfuls) orally every 4 hours as needed for chest congestion or cough."</p> <p>Review on 1/23/13 at 1:35 PM of the MAR for January 2013 indicated client A was administered the PRN for Guiatuss 30 ML on the morning of 1/2/13 and 3 times daily (morning, dinner, bedtime) on 1/3/13, 1/4/13, 1/5/13, 1/6/13, 1/7/13, and 1/8/13.</p> <p>Review on 1/23/13 at 1:38 PM of the MAR for January 2013 indicated client A was administered the PRN for Robafen-DM syrup 4 times daily (morning, lunch, dinner, bedtime) on 1/1/13, 1/2/13, 1/3/13, 1/4/13, 1/5/13,</p>						

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	<p>1/6/13, 1/7/13, and at bedtime on 1/8/13.</p> <p>On 1/23/13 at 2:20 PM, interview with RN (registered nurse) #1 indicated she just reviewed client A's MAR for January 2013 and called the pharmacy regarding staff giving both the Robafen-DM and Guiatuss for cough to client A simultaneously. She indicated it would not be normal procedure to give 2 PRN medications for cough but wasn't sure if it was contraindicated for client A. RN #1 indicated it is not within facility policy for staff to call for authorization to give a PRN unless symptoms such as chill or fever were present.</p> <p>On 1/24/13 at 12:05 PM, interview with Pharmacist #1 indicated both Robafen-DM and Guiatuss have the same active ingredient of Guaifenesin. Pharmacist #1 indicated client A was administered up to 2600 mg/daily of Guaifenesin when both PRN cough medications (Robafen-DM and Guiatuss) were given at full daily doses (1/3-1/7/13) which is above the 2400 mg/day maximum recommended dose. No further documentation was presented to indicate a physician recommended a higher daily dose of Guaifenesin than the recommended maximum daily allowance.</p> <p>9-3-6(a)</p>						

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview, the facility failed to assure 1 of 3 sampled clients (client A) utilized a gait belt as indicated.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/22/13 at 11:34 A.M.. The review indicated the following incidents involving client A:</p> <p>"Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory tests) were all normal. A CAT scan (computerized scan) of the head, chest</p>			W0436	<p>CL A had appointments with a physical therapist on _____ and _____ which she was unable to attend due to her hospitalizations. The intention of these appointments was to identify the correct adaptive equipment and/or lifting devices which would be the least restricting CL A. Current consumers do not require the assistance of a Hoyer lift, so no additional equipment or space is required. In the event that the conditions of these or future consumers change they will be evaluated for assistive devices and alternatives that meet the needs of the client and work with in the allotted space will be obtained.</p>		02/19/2013

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	<p>and abdomen came back normal also. Consult with surgeon for spinal stenosis came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities."</p> <p>Client A's record was reviewed on 1/22/13 at 12:03 P.M.. The review failed to indicate the PT/OT evaluation.</p> <p>Client A's record was reviewed on 1/22/13 at 12:03 P.M.. The review failed to indicate the PT/OT evaluation.</p> <p>"Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hooyer lift (lifting device) should be implemented as soon as possible." Further review of the 12/31/12 incident</p>						

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	<p>indicated action taken by LPN (Licensed Practical Nurse) #1: "[Client A] was refusing staff assistance on the evening of the 28th (12/28/12). When staff attempted to transfer her she fought and slid down to the floor. No injury occurred from that but staff called for assistance to get her (client A) off the floor. She (client A) sustained the bruise and scratch while getting her up and into bed."</p> <p>"Date: 01/08/2013, Name: [client A], Narrative: Received phone call from group home staff approximately 9:00pm stating that [client A] had slid herself down, with staff assistance, to the floor. {This behavior is in her behavior plan}. Staff needed assistance to get her up since [client A] is unable to assist. Instructed staff to call area manager to send additional staff over to help. Received a second call for staff stating that [client A] had stopped breathing and 911 had been called. Plan to Resolve: Second staff started CPR (Cardio-Pulmonary Resuscitation) and continued until medics arrived and took over. [Client A] was taken to [local hospital] and intubated (breathing tube placed). She remains on life support at this time."</p> <p>Client A's record was reviewed on 1/22/13 at 12:01 P.M.. A review of the client's 1/12 behavior management plan</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 01/28/2013	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410			
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	<p>failed to indicate client A had an addressed behavior of sliding down to floor from a seated position. A 11/27/12 facility nursing assessment indicated the client was, "Very tired and lethargic. Won't feed herself or help transfer. Review of a hospital discharge summary, dated 12/12/12, included a Rehab (rehabilitation) Evaluation which indicated client A had Rehab Diagnoses which included but were not limited to: "Frequent fall with chest pain, and, Gait disturbance with General weakness." A review of client A's "Fall Risk Plan", dated 11/12, indicated "[Client A] uses a wheelchair and a gait belt to ambulate."</p> <p>Direct care staff #1 was interviewed on 1/22/13 at 5:45 P.M.. Direct care staff #1 stated client A "would not help with transfers and would often slide to the floor when being transferred due to her weakness." When asked if client A had any lift or gait belt to assist in transferring her, direct care staff #1 stated, "She (client A) didn't have a gait belt that I know of."</p> <p>Direct care staff #2 was interviewed on 1/23/13 at 9:55 A.M.. When asked if client A had a gait belt or any other device to assist with transfers, direct care staff #3 stated, "No, no gait belt."</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

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	<p>LPN #1 was interviewed on 1/23/13 at 12:01 P.M.. LPN #1 stated, "[Client A] required two person transfers. No devices (hoyer lift or gait belt) were being used."</p> <p>This federal relates to complaint #IN00122535.</p> <p>9-3-7(a)</p>						